

Culture and Medicine

Complementary medicine use by Mexican migrants in the San Francisco Bay Area

The number of clinical studies on the efficacy of complementary and alternative medicine (CAM) in the United States has risen dramatically since the end of the 1990s. Many of these investigations, mostly clinical trials, have received national funding from the National Center for Complementary and Alternative Medicine. Little support has been directed to anthropologic studies of the use of CAM among minority populations, such as Mexican migrants. As the Mexican migrant population continues to grow, however, it is important for physicians to understand CAM and its use among this population group.

The focus of this article is on the needs and attitudes of Mexican migrants seeking CAM treatments and the conditions required for CAM delivery to this specific cultural group. The scientific validity and efficacy of CAM therapies are not addressed.

THE MEXICAN MIGRANT POPULATION

An important stream of migration from Mexico to California began in 1942 with the “Bracero program,” which lasted until the middle of the 1970s. This program was formed, by agreement between Mexico and the United States, during World War II in response to a labor shortage of men in the agricultural sector. As a result, the first immigrant wave brought workers from Mexico who found seasonal employment. Mostly men, they came to rural areas. In later years, the migrant workers brought their families to the United States, especially after changes in US immigration policy, such as the promotion of the 1986 Immigration Reform and Control Act.

At present, the migrant population has diversified. In California, most Mexican migrants come from the western and central regions of Mexico, such as Jalisco, Michoacán, and Nayarit. They are no longer just agricultural workers, however; they are part of the growing formal and informal urban economy, working in commercial establishments, as housemaids, or in less formal jobs, such as daily work in the construction or landscape industries. It is among this urban Mexican migrant population that I conducted my research. Most of the people that I interviewed were either US residents or were undertaking the lengthy process of acquiring full legal residency.

ORIGINS OF CAM USE BY MEXICAN MIGRANTS

The use of CAM has been increasing in Mexico, not only among the middle and upper socioeconomic classes,¹ but also among the low-income population.² Two factors led to this increase—an expanding web of CAM practitioners

Summary points

- Better understanding is needed of culturally specific uses of complementary and alternative medicine (CAM) by Mexican migrant populations in the United States
- Homeopathic medicine is practiced widely in Mexico, but few Spanish-speaking homeopaths practice in the Bay Area
- Homeopathy, as with other types of CAM, can provide a context for healing for migrant workers and their families

and a long tradition in Mexico of self-help medicine, known as *medicina popular*. An umbrella term, *medicina popular* encompasses acupressure, reflexology, herbal remedies, Bach Flower Remedies, massage, and basic homeopathic treatment.

Such self-help medicine received “official” recognition in the mid-1970s when the World Health Organization ran a program to develop traditional medicine in Mexico. Its aim was to develop practical methods of self-help based on the model of the “barefoot doctors” in China (see box).^{3,4}

Medicina popular also spread through networks that overlapped with religious movements, such as Liberation Theology and Catholic evangelization.⁵ In Mexico, the World Health Organization’s program of *medicina popular* was hampered rather than facilitated by government policy, which is why subsequent efforts to promote this type of medicine were led by educational and religious

The “barefoot doctors” in China

- During the Chinese Revolution, knowledgeable and educated people helped organize forms of primary community health care. Those people, called barefoot doctors, combined acupuncture and homemade remedies, and referred patients to Western doctors only if their own primary intervention had not succeeded.
- The Chinese traditional medical system has been handed down primarily through written texts and has maintained a certain unity, whereas the Mexican medical system has been transmitted orally and is more heterogeneous and fragmented. This heterogeneity is one of the main reasons why a national plan of self-help training groups, on the model of the barefoot doctors, is important in Mexico.

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groups, rather than ministerial ones. This promotion by nongovernment groups has been seen as a form of resistance to the institutionalized order.¹⁻⁵

The use of self-help remedies, and their teaching through popular and educational organizations, has grown among the low-income population to which most newly arrived Mexican migrants to California belong.

THE AVAILABILITY OF CAM IN THE BAY AREA

Between January 1999 and April 2000, I undertook fieldwork on the use of CAM among the Mexican migrant population in the San Francisco Bay Area. A preliminary anthropologic study on the holistic movement in the Bay Area had previously been published.⁶ In my own study in the region, I observed 3 different, although overlapping, forms of CAM health care available to the Mexican migrant population.

Organized health centers

One form of CAM is provided by newly organized health centers that provide a combination of biomedical and CAM treatments to the local population at a reasonable price. An ongoing experiment is the Integrative Center for Culture and Healing (www.icchsf.org), which is in part financed and supported by St Luke's Hospital in the Mission District of San Francisco. This center provides a range of body work (massage, Alexander technique) and energy work (Reiki), as well as traditional Chinese medicine and preparation for surgery, for a diverse population that comprises a small, but growing, percentage of Latinos.

Spanish-speaking practitioners

There are a small number of Spanish-speaking practitioners who provide CAM services from private practices.

Casas de Salud

These stores sell herbs and supplements and may have a specialist health adviser on site who, for a relatively small fee, can advise on nutrition, herbal remedies, and health education.

UNDERSTANDING CAM PRACTICES IN THE MEXICAN POPULATION

Practitioner networks

Anthropologists have explored some of the different historical and social roots of CAM by stressing their historical relation to the turn-of-the-century European Romantic tradition⁷ and to faith healing in American religious practices during the 19th and early 20th centuries.⁸

Sharma, for example, studied CAM practices in the United Kingdom at the beginning of the 1990s and argued that the majority of CAM practitioners have an in-

dividualistic tendency, preferring to work in isolation rather than in teams.⁹

However, Sharma's model of an exclusive interaction between patients and practitioners and of competition among practitioners themselves is not true for other cultures. In specific regions of Mexico, such as in Morelos, patients may see several different CAM practitioners regularly, and many practitioners are in regular contact with each other, forming a network of mutual exchange, teaching, and practice.¹⁰ Hence, the United Kingdom's "individualism"—the aspiration to self-employment within an open market of CAM practice—cannot be assumed without looking at the specific national, regional, and local conditions.

Regionalism

It is vital for health care practitioners working with a Mexican migrant population to understand what "Mexican" can mean.

Most Mexican migrants to the Bay Area originate from the state of Jalisco, the cradle of rancher culture since indigenous communities were nearly wiped out in the 17th century. The state, influenced by the Catholic Church and Spanish colonial culture, is characterized by an oligarchic social system, strong patriarchal family values, and Catholic beliefs. These characteristics of the region distinguish it from states such as Oaxaca, Michoacán, or Quintana Roo.

These last regions have a higher number of indigenous people and a different relationship to the centralized health care system. Areas of the Mexican republic differ in the degrees of harmony between traditional medicine and biomedicine.

Physicians should avoid the pitfall of thinking of Mexican migrants as "exotic" people coming from a poor urban or farming society. Many who find their way to the Bay Area come from—even if they were not born in—increasingly urbanized and complex areas where biomedicine coexists with different forms of CAM and traditional medicines.

In Mexico, many people use over-the-counter medicines and self-diagnosis, which are a way to cut the costs of biomedical and CAM consultations in a time of economic hardship.¹¹ The choice of what to use is often dictated by its cost and its reported efficacy among family and friends. Hence, most people from urban areas of Mexico are acquainted with an increasingly wide spectrum of medical care, which is accessed across class, regional, and ethnic boundaries.

An interesting question is whether migrants' length of stay in California reduces their interest in CAM therapies. Results of my research suggest that there are cost and language constraints in accessing CAM rather than a loss

CAM practitioners trained in Mexico may find it hard to maintain a stable clientele

Manuel is a homeopath trained in Mexico who is practicing in the Mission District, a neighborhood in San Francisco that is predominantly Latino. His patients come from different parts of the Bay Area. He trained at the University of Guadalajara, Jalisco, but to practice in California, he has had to take an additional specialized course through the British Homeopathic Association. Even after 4 years in the same practice, he has difficulties maintaining a stable clientele, despite having taken training courses in Reiki, nutrition, and acupuncture.

of faith or confidence in CAM once they cross the border and settle in the United States.

Why are there so few Spanish-speaking CAM practitioners?

In the San Francisco Bay Area, I traced only a few Spanish-speaking practitioners of acupuncture, homeopathy, and body work (such as the Rosen and Feldenkrais methods, and Rolfing). Clear and accessible information on CAM written in Spanish was lacking, but the people I interviewed often reported they were witnessing an “*explosión de lo natural*”—a huge increase in CAM use. Two questions come to mind. Why is the training in CAM still not attractive to second-generation Mexicans or other Latinos who could provide a Spanish-speaking service to the Mexican migrant population? And why are so few individuals from Mexico and other Central American countries trained as CAM practitioners in the Bay Area?

Several factors should be considered when attempting to offer answers. The symbolic role and status of the biomedical profession within Mexico—even if in reality the public medical profession is underpaid and underfunded—encourage second-generation migrants to look for more stable income in the biomedical professions rather than becoming self-employed CAM professionals. An acupuncture student brought up in El Salvador explained: “It is very difficult to make money in these professions.” The issue, therefore, is not only access to CAM treatments and “navigating” public and private systems that provide CAM, but also the long-term income that such training can offer to a diverse Mexican and Latino population.

Another relevant issue is the regulation of CAM practitioners across international borders. For instance, homeopaths who have trained in Mexican schools are not eligible for licensure in California without further training and examination in the United States (see box).

TENSIONS BETWEEN CAM PRACTITIONERS AND FAITH HEALERS

Spanish-speaking CAM practitioners, like Manuel, pointedly distance themselves from *curanderos*, or faith healers.

Practitioners of CAM, as well as migrant Latino women with an interest in CAM who are involved in community health worker study programs, want to be perceived as professionals providing an educational service that leads to healthy changes in attitudes and lifestyle. This focus of CAM is distinct from that of religious healing—such as *curanderismo* and *santería*—which relies on the idea that illness comes from somewhere outside oneself. CAM practitioners believe that religious healing, therefore, causes people to live in fear rather than to act on what they have learned on their own.

For some of the patients who attend Manuel’s practice, however, this distinction is less defined. What motivates them to seek homeopathy might also lead them to seek faith healing; for example, many face a fear of *fracasar*—failing in marriage, or failing to provide a proper upbringing for their children in the United States.

THE USE OF HOMEOPATHY BY MEXICAN MIGRANTS

The demand for homeopathic care among the Spanish-speaking population in the Bay Area, although less than that in Mexico, is still greater than what can be provided by the few Spanish-speaking practitioners who can provide this service at an affordable price. Some Mexican migrants must maintain a telephone relationship with their homeopaths back in Mexico.

When Mexican migrants were asked why they sought homeopathic care, the most common response was that “it did not harm” and that it worked especially for *los nervios* (nerves). Beyond these explanations, there emerged a pow-



The Mission District of San Francisco, traditionally a Latino area, is being gentrified since the explosion of “dot com” companies



Paul Sakuma/AP

The Mexican migrant population adds to the diversity of the San Francisco Bay Area

erful desire to talk and to be heard. Women who attend Manuel's practice praise him for his capacity to listen. One woman said, "He is the first doctor who has listened to me." The homeopath, therefore, provides an ear for patients to relate problems with household responsibilities, detrimental diet changes, sexual and partnership difficulties, and a general overall fatigue due to long labor shifts. (In many Mexican migrant households, parents often work double shifts.) The demands of juggling work, family life, and legal status, coupled with the sense of loss built into the migratory process, take a toll on people's—and especially on women's—health. Manuel remarked that people "tienen coraje con este país" (have resentment/rage with this country) and that homeopathy helps them deal with the suffering and pain of being far away from their places of origin, especially at times of family mourning.

The Mexican migrant population sees CAM as part of a spectrum of treatment possibilities rather than a superior form of medical provision. Illness has many different physiologic, psychologic, and cultural aspects, and different kinds of medical care can address these different areas. The migrant population perceives that CAM therapies, and especially homeopathy, are not invasive and that the diagnostic, patient-doctor encounter allows the patient to spend time "opening up" about their problems.

The homeopathic diagnosis requires a verbal exchange and an understanding of the subtleties of body language and verbal communication. Homeopathy also is a treatment that is repeated and developed over time. Therefore, the mastery of Spanish is important for this practice to be effective. As the Spanish-speaking population grows, so does the need for bilingual, trained professionals who are able to provide quality CAM therapy.

CONCLUSION

To successfully open the health market to Spanish-speaking CAM professionals, the United States and Mexico must recognize high-standard CAM training in either country as sufficient to practice in the United States. Such recognition must emerge out of greater understanding of the everyday use and meanings of specific, culturally located CAM practices. The practice of CAM in a transnational and multicultural context affects both patients and practitioners.

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capsule

Should pregnant women be screened for diabetes? Guidelines from the American Diabetes Association recommend screening for gestational diabetes in all pregnant women. This policy has had little effect on rates of complications related to diabetes, but it may be responsible for a 9-fold increase in the recorded incidence of the disease, according to a results of a time-trends study from Canada (*Am J Epidemiol* 2000;152:1009-1014). Use of routine screening remains controversial, say the authors, who recognize the need for randomized trials to make sure screening does more good than harm.